DESCRIPTION OF PROGRAMS/SERVICES

Clinical Units:

Mid-Missouri Mental Health Center's clinical services are divided into two basic services: adult and child. Members of the clinical staff are, by and large, attached to these services. The organizational relationships of each of the Center's programs (including channels of staff communication, responsibility, and authority as well as supervisory relationships) are outlined in the Staff Composition subsection and Organizational Charts.

Adult Inpatient Services:

The Adult Inpatient Psychiatric Units provide inpatient services to patients, age 18 years or above, from an 18-county catchment area. Adult Inpatient Services is divided into three multidisciplinary units: 2-North (18 beds), 2-South (20 beds), and 3-South (21 beds).

Hours of Operation.

The units operate 24-hours a day, 7 days a week with nursing and medical/psychiatric coverage. In addition, Recreation Therapy provides services during the evening and on weekends. All other professional staff are present from 8:00 a.m. to 4:30 p.m., Monday through Friday. Intake and screening of individuals presenting for unscheduled care are available 24 hours per day. Those patients needing emergency services beyond Mid-Missouri Mental Health Center's capabilities are transferred to the appropriate Emergency Room. If the patient is admitted, the Mid-Missouri Mental Health Center backup Attending Physician is consulted.

Screening, Intake, and Admissions Procedures.

Individuals are referred to the Adult Inpatient Psychiatric Units from a variety of sources including the Administrative Agents, by private physicians, other agencies within the catchment area, by the courts, self-referral, or referral by families/significant others. Patients are accepted for treatment on a first-come basis except for court commitments which are obligatory admissions. Upon receiving a referral for inpatient admission, the Admissions Coordinator (a licensed Registered Nurse) determines the appropriateness of admission in consultation with the Medical Director, or their designee, during regular working hours. After hours, the resident on call is responsible for admissions.

For emergency cases, defined as individuals presenting for unscheduled care or services on Mid-Missouri Mental Health Center grounds, MMMHC Policy 11.05.03 is to be followed. The adult admissions coordinator and/or the nurse supervisor will do a face-to-face evaluation of the prospective patient, which will include entry into the

admission/screening log book and completing the mental health screening for psychiatric disturbances. The nurse supervisor or their designee will assess vital signs and record them on the physical exam form. A physician will do an assessment of the individual and complete a disposition of evaluation as outlined in MMMHC Policy 11.05.06.

After an admission, the patient is assigned to a multi-disciplinary treatment team. Immediately upon entering the ward, the patient will be interviewed by a member of the nursing staff and the admission workup will be completed by the designated physician.

Criteria for Admission.

1) Individuals who are dangerous to self and/or others as a result of mental illness.
2) Impaired contact with reality manifested by hallucinations, delusions, or ideas of reference, withdrawal, regression, or confusion, paranoid ideation, or behavior.
3) Severe disorganization in thinking, emotion, and behavior.
4) Impaired family, social, occupational, and academic functioning due to psychiatric disorder or severe disabling somatic symptoms.
5) Individuals in need of 24-hour observation in order to complete an evaluation and/or adjust medication.
6) Failure to manage psychiatric illness on an outpatient basis.
7) Involuntary commitments.

Exclusion Criteria.

1) Individuals who are not actively suicidal or homicidal and can be adequately managed in a less restrictive environment.

2) Individuals who have a physical illness which requires intensive medical/nursing intervention not available on a psychiatric unit.

3) Individuals who have been charged with a major crime defined as:

- abuse of a child pursuant to subdivision (2) of subsection 3 of section 568.060, RSMo [(2) A child dies as a result of injuries sustained from conduct chargeable pursuant to the provisions of this section] **
- arson in the first degree **
- assault in the first degree **
- assault of a law enforcement officer in the first degree **
- attempted forcible rape if physical injury results
- attempted forcible sodomy if physical injury results
- domestic assault in the first degree **
- elder abuse in the first degree **
- forcible rape
- forcible sodomy

- kidnapping **
- murder in the first degree **
- murder in the second degree **
- robbery in the first degree **
- sexual assault **
- statutory rape in the first degree when the victim is a child less than twelve years of age at the time of the commission of the act giving rise to the offense**
- statutory sodomy in the first degree when the victim is a child less than twelve years of age at the time of the commission of the act giving rise to the offense**

** or the attempts thereof

4) Individuals who are detained in a local correctional facility and/or have been sentenced to the Department of Corrections but remain in county jail awaiting transfer, are considered escape risks by the Sheriff, or have exhibited violent behavior in jail may be beyond Mid-Missouri Mental Health Center's control.

Assessment and Evaluation Services.

The three Adult Inpatient Psychiatric Units are composed of multi-disciplinary teams. Each routinely provides evaluation and assessment in the following areas: psychiatry, nursing, social service, rehabilitation services, and psychology. In addition, pastoral services are available.

The patient is seen by a physician within one hour of admission. An initial biopsychosocial assessment will be completed and written up within 24 hours. The physician's assessment of the patient, including a mental status examination, will be conducted within the first hour. The admissions diagnosis is given on all five Axes per DSM-IV (TR) and a preliminary treatment plan is written. The patient who has been committed will have their rights and responsibilities read by a member of the nursing staff or a physician within three hours after admission to the unit. Voluntary patients will have their rights and responsibilities given to them by the nursing staff and will be oriented to the ward. If at all possible, the social worker and physician will interview any family members present with the patient at the time of admission. Arrangements will be made for the patient to retain personal clothing and a private area to keep some personal belongings.

A diagnostic staffing will be held within 72 hours of admission. The staffing will consist of the entire team, with representation from each discipline, as needed. The essential staff that must be present are the Psychiatrist, Nurse, and Social Worker. At the staffing, the patient will be interviewed, an assessment of the patient's needs and strengths will be made, and a working diagnosis will be formulated. In addition, a primary therapist/case manager will be assigned to the patient, who will be

responsible for the management of the case and individual psychotherapy when indicated.

Treatment Modalities.

The individualized treatment plan is the basic tool used to document the treatment process. The plan identifies treatment objectives as well as the methods through which the patient can achieve specific goals. The multidisciplinary treatment team develops the treatment plan with input from the patient, parent, guardian, or significant others. The plan identifies problems or needs of the patient, delineates the treatment modalities which would be utilized as well as the staff member who will be responsible for the intervention.

The Initial Treatment Plan is developed within the first hour of admission. The Comprehensive Treatment Plan is developed within the first 72 hours of hospitalization and the Treatment Plan Review is completed five (5) days after completion of the Comprehensive Treatment Plan and on a weekly basis thereafter.

Treatment modalities include individual, marital, family, and group therapies, pharmacotherapy, occupational therapy, recreational therapy, and community outings, dual diagnosis programming, aftercare and discharge planning.

Aftercare Planning.

Discharge and aftercare planning begins at admission, starting with the treatment planning process and is ongoing until the time of discharge. Input is provided by all members of the treatment team, however, the primary therapist/case manager is responsible for coordinating these services. Aftercare services including crisis numbers are offered to all patients, even those leaving against medial advice. Arrangements for followup are coordinated with the patient or guardian, a copy of these plans are sent with the patient , and a copy of the plan and pertinent documents are sent to the community agency or placement facility within 48 hours.

To enhance continuity, the Social Service Director functions as a liaison to all the Administrative Agents, assists in coordinating planning meetings, and attends Central Regional Case Conferences. Social Service staff from each of the inpatient units collaborate with representatives of DMH Administrative Agents or affiliates. Special facility case conferences focusing on interagency community service (wraparound) planning is coordinated on an "as needed" basis. Such services may be coordinated through the use of teleconferences.

A discharge summary/discharge note will be entered in the patient's medical record within 15 days following discharge and shall be completed according to Medical Records and Utilization Review policy. The Aftercare Plan and the physician's Discharge Plan are completed prior to discharge. One copy is given to the patient and one copy remains in the patient’s medical record.

All staffings, treatment, and discharge planning by clinicians on the Adult Inpatient Psychiatric Unit are supervised by a board certified or board eligible psychiatrist.

Discharge Criteria.

1) Patients admitted for suicidal/homicidal behavior are no longer a threat to themselves or others.
2) Patients admitted for impaired reality testing ability due to hallucinations, delusions, and/or ideas of reference, for whom progress indicates amelioration of symptoms to such a degree that sufficient contact with reality is restored to function in everyday life.
3) Patients initially admitted because of inability to function in daily life have regained or acquired this ability.
4) Patients committed by court no longer represent a threat to self or others.
5) Patients can be treated in a less restrictive environment.
6) Patient needs of acute medical care cannot be met at this facility; such patients are discharged to the appropriate medical facility.